



Request for Inactive Status

Rhode Island Department of Health
Licensing Data Entry Unit
Room 105A
3 Capitol Hill
Providence, RI 02908-5097
Phone: 401-222-1800
Fax: 401-222-1751
elicense@health.ri.gov

Note: This form only applies to the license types listed below. If you do not see your license type listed below you cannot use this form.

Information and
Instructions:

Please Print

- Please complete and sign this form and either fax or mail to the fax number or address provided above. Please keep a copy of this for your records.
- There is **no fee** to be placed on Inactive Status.
- You cannot practice in the State of Rhode Island while on this status.
- If you wish to reactivate your license please contact your Licensing Board. To obtain Board contact information please visit our website at:
<http://www.health.ri.gov/hsr/professions/index.php>

Mark with an (X) the License Type you wish to place on Inactive Status:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Allopathic Physician (MD) | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Nurse Practitioner Prescriptive | <input type="checkbox"/> Practical Nurse | <input type="checkbox"/> Respiratory Care Practitioner |
| <input type="checkbox"/> Marriage and Family Therapist | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Psychiatric CNS | <input type="checkbox"/> Speech Lang. Pathologist |
| <input type="checkbox"/> Mental Health Counselor | <input type="checkbox"/> Occupational Therapist Assistant | <input type="checkbox"/> Psychiatric CNS Prescriptive | |
| <input type="checkbox"/> Nurse Anesthetist | <input type="checkbox"/> Osteopathic Physician (DO) | <input type="checkbox"/> Psychologist | |

Name: _____
First Name Middle Last Name

License Number: _____

Home Address: _____
Address Line 1

Home Phone Number: () -

Address Line 2

Home Fax Number: () -

Address Line 3

Home Email : _____

Address Line 4

Work Address: _____
Address Line 1

Work Phone Number: () -

Address Line 2

Work Fax Number: () -

Address Line 3

Work Email : _____

Address Line 4

Signature

Date